

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

15668

State File No.

FILED MAY 14 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4121**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3310 Lucas 0	
3. NAME OF DECEASED (Type or Print) a. (First) Joe b. (Middle) c. (Last) Farmer		4. DATE OF DEATH (Month) (Day) (Year) April 18 1953	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH UNKNOWN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 66	11. BIRTHPLACE (State or foreign country) UNKNOWN 9
13a. FATHER'S NAME NOT KNOWN		13b. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 427-16682	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ELNOR R Reed 3310 LUCAS	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Insufficiency		INTERVAL BETWEEN ONSET AND DEATH Undet.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last. DUE TO (b) Glomerulonephritis, Chronic DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 592x	
22. I hereby certify that I attended the deceased from 4-11 , to 4-18 , 19 53 , that I last saw the deceased alive on 4-18 , 19 53 , and that death occurred at 12:47a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edna E. Brooks M.D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 4-20-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 4-24-53	24c. NAME OF CEMETERY OR CREMATORY CLARKSON HILL MISS.	24d. LOCATION (City, town, or county) (State) MISSISSIPPI
DATE REC'D BY LOCAL REG. APR 21 1953	REGISTRAR'S SIGNATURE Charles Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DAVIS-BROOK 1405 Biddle St	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Leroy W. Pannister

Licensed Embalmer No. *4523*

P. O. Address *3880 Easton Ave*

Note: -The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.